

AMENDED IN ASSEMBLY JUNE 13, 2002

AMENDED IN ASSEMBLY JUNE 10, 2002

AMENDED IN SENATE APRIL 30, 2002

SENATE BILL

No. 1531

Introduced by Senator Speier

February 20, 2002

An act to amend Sections 1358.11 and 1358.12 of, and to add Section 1358.24 to, the Health and Safety Code, and to amend Sections 10192.11 and 10192.12 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1531, as amended, Speier. Health care coverage.

Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and for the regulation of health insurers by the Department of Insurance. Under existing law, a violation of the provisions governing health care service plans is punishable as a crime.

Existing law requires a plan and a health insurer to issue a Medicare supplement policy on a guaranteed basis to specified individuals, including those enrolled in a Medicare+Choice plan, who satisfy designated criteria. Under existing federal law provisions regulating those plans, a Medicare+Choice organization may apply to the United States Department of Health and Human Services Centers for Medicare and Medicaid Services for a modification of a service area of a Medicare+Choice plan that it offers. Existing law additionally provides that a plan and a health insurer may not deny, condition the offering or effectiveness of, or discriminate in the pricing of a Medicare

supplement policy or contract because of, among other things, the health status, claims experience, or a preexisting condition, of an applicant if the applicant satisfies designated criteria. Existing law provides an applicant for a Medicare supplement policy or contract with an open enrollment period in specified situations if the applicant, among other things, is at least 65 years old and was previously enrolled in Medicare.

This bill would expand eligibility for the guaranteed issuance of a Medicare supplement policy to include an individual enrolled in a Medicare+Choice plan if the plan reduces its benefits, increases the cost-sharing amount, or discontinues for other than good cause relating to the quality of care, a provider currently furnishing services to the individual. The bill would also require a Medicare+Choice organization to submit to the Department of Managed Health Care all of the information included in any service area modification request it makes and would require the department to issue an advisory opinion addressing certain issues relating to the request. The bill would expand the ability of a qualified applicant to obtain a Medicare supplement policy or contract by, among other things, deleting the age requirement and expanding the open enrollment timeframe, as specified.

Because the bill would specify additional requirements with respect to the operation of a health care service plan, the violation of which would be punishable as a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 1358.11 of the Health and Safety Code
- 2 is amended to read:
- 3 1358.11. (a) An issuer shall not deny or condition the
- 4 offering or effectiveness of any Medicare supplement contract
- 5 available for sale in this state, nor discriminate in the pricing of a



1 contract because of the health status, claims experience, receipt of
2 health care, or medical condition of an applicant in the case of an
3 application for a contract that is submitted prior to or during the
4 six-month period beginning with the first day of the first month in
5 which an individual is both 65 years of age or older and is enrolled
6 for benefits under Medicare Part B. Each Medicare supplement
7 contract currently available from an issuer shall be made available
8 to all applicants who qualify under this subdivision and are 65
9 years of age or older. Medicare supplement contracts A, B, C, F,
10 and at least one letter-designated plan (H, I, or J, at the discretion
11 of the issuer) that includes coverage for prescription medications,
12 if currently available from an issuer, shall be made available to any
13 applicant who qualifies under this subdivision who is 64 years of
14 age or younger and who does not have End-Stage Renal Disease.
15 This section ~~does~~ and Section 1358.12 do not prohibit an issuer in
16 determining subscriber rates from treating applicants who are
17 under 65 years of age and are eligible for Medicare Part B as a
18 separate risk classification.

19 (b) (1) If an applicant qualifies under subdivision (a) and
20 submits an application during the time period referenced in
21 subdivision (a) and, as of the date of application, has had a
22 continuous period of creditable coverage of at least six months, the
23 issuer shall not exclude benefits based on a preexisting condition.

24 (2) If the applicant qualifies under subdivision (a) and submits
25 an application during the time period referenced in subdivision (a)
26 and, as of the date of application, has had a continuous period of
27 creditable coverage that is less than six months, the issuer shall
28 reduce the period of any preexisting condition exclusion by the
29 aggregate of the period of creditable coverage applicable to the
30 applicant as of the enrollment date. The manner of the reduction
31 under this subdivision shall be as specified by the director.

32 (c) Except as provided in subdivision (b) and Section 1358.23,
33 subdivision (a) shall not be construed as preventing the exclusion
34 of benefits under a contract, during the first six months, based on
35 a preexisting condition for which the enrollee received treatment
36 or was otherwise diagnosed during the six months before the
37 coverage became effective.

38 (d) An individual enrolled in Medicare by reason of disability
39 shall be entitled to open enrollment described in this section for six
40 months after he or she enrolled in Medicare Part B, or if notified

1 retroactively of his or her eligibility for Medicare, for six months
2 following notice of eligibility. Sales during the open enrollment
3 period shall not be discouraged by any means, including the
4 altering of the commission structure.

5 There shall be a one-time open enrollment period of ~~180~~ 90 days
6 commencing on January 1, 2004, for all individuals eligible for
7 Medicare by reason of disability who do not have End-Stage Renal
8 Disease *and who did not use the prior one-time open enrollment*
9 *that commenced on January 1, 2001*. Notice of this one-time open
10 enrollment right shall be publicized on the Web sites of the
11 Department of Managed Health Care, the Department of
12 Insurance, and the Department of Aging, through *those*
13 *departments'* written materials directed to Medicare beneficiaries,
14 and by the Health Insurance Counseling Advisory Program
15 (HICAP), beginning January 1, 2003.

16 (e) An individual enrolled in Medicare Part B is entitled to open
17 enrollment described in this section for six months following:

18 (1) Receipt of a notice of termination or loss of eligibility *due*
19 *to the divorce or death of a spouse* or, if no notice is received, the
20 effective date of termination or loss of eligibility *due to the divorce*
21 *or death of a spouse*, from any employer-sponsored health plan
22 including an employer-sponsored retiree health plan. For purposes
23 of this section, "employer-sponsored retiree health plan" includes
24 any coverage for medical expenses that is directly or indirectly
25 sponsored or established by an employer for employees or retirees,
26 their spouses, dependents, or other included covered persons.

27 (2) Termination of health care services for a military retiree or
28 the retiree's Medicare eligible spouse or dependent as a result of
29 a military base closure or loss of access to health care services
30 *because the base no longer offers services or because the*
31 *individual relocates*.

32 (f) An individual enrolled in Medicare Part B is entitled to open
33 enrollment described in this section if the individual was covered
34 under a policy, certificate, or contract providing Medicare
35 supplement coverage but that coverage terminated because the
36 individual established residence at a location not served by the
37 issuer.

38 (g) (1) An individual whose coverage was terminated by a
39 Medicare managed care plan shall be entitled to an additional
40 60-day open enrollment period to be added on to and run

consecutively after any open enrollment period authorized by federal law or regulation, for any and all Medicare supplement coverage available on a guaranteed basis under state and federal law or regulations for persons terminated by their Medicare managed care plan.

(2) Health plans that terminate Medicare enrollees shall notify those enrollees in the termination notice of the additional open enrollment period authorized by this subdivision. Health plan notices shall inform enrollees of the opportunity to secure advice and assistance from ~~their area (HICAP)~~ *the HICAP in their area*, along with the toll-free telephone number for HICAP.

(h) An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement coverage that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, no issuer that falls under this provision shall deny or condition the issuance or effectiveness of Medicare supplement coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy, certificate, or contract. An issuer that offers Medicare supplement contracts shall notify an enrollee of his or her rights under this subdivision at least 30 and no more than 60 days before the beginning of the open enrollment period.

SEC. 2. Section 1358.12 of the Health and Safety Code is amended to read:

1358.12. (a) (1) With respect to the guaranteed issue of a Medicare supplement contract, eligible persons are those individuals described in subdivision (b) who apply to enroll under the contract not later than 63 days after the date of the termination of enrollment described in subdivision (b), and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement contract.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement contract described in subdivision (c) that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of the Medicare supplement contract because of

1 health status, claims experience, receipt of health care, or medical
2 condition, and shall not impose an exclusion of benefits based on
3 a preexisting condition under the Medicare supplement contract.

4 (3) Issuers shall issue coverage with an effective date not later
5 than the date of termination of previous benefits or the date
6 requested on the application, but in no event earlier than the date
7 of application for coverage. *Issuers shall issue coverage so that*
8 *there is no duplication or overlap of coverage.*

9 (b) An eligible person is an individual described in any of the
10 following paragraphs:

11 (1) The individual is enrolled under an employee welfare
12 benefit plan that provides health benefits that supplement the
13 benefits under Medicare, and the plan terminates, the individual
14 loses his or her eligibility to continue benefits *due to the divorce*
15 *or death of a spouse*, or the plan ceases to provide some, all, or
16 substantially all of those supplemental health benefits to the
17 individual ~~or~~ and the employer no longer provides the individual
18 with insurance that covers all of the payment for the Part B
19 20-percent coinsurance.

20 (2) The individual is enrolled with a Medicare+Choice
21 organization under a Medicare+Choice plan under Medicare Part
22 C, and any of the following apply:

23 (A) The organization's or plan's certification, under this part,
24 has been terminated or the organization has terminated or
25 otherwise discontinued providing the plan in the area in which the
26 individual resides.

27 (B) The individual is no longer eligible to elect the plan because
28 of a change in the individual's place of residence or other change
29 in circumstances specified by the secretary, but not including
30 termination of the individual's enrollment on the basis described
31 in Section 1851(g)(3)(B) of the federal Social Security Act, where
32 the individual has not paid premiums on a timely basis or has
33 engaged in disruptive behavior as specified in standards under
34 Section 1856 of that act, or the plan is terminated for all individuals
35 within a residence area.

36 (C) The individual demonstrates, in accordance with
37 guidelines established by the director, either of the following:

38 (i) The organization offering the plan substantially violated a
39 material provision of the organization's contract under this article
40 in relation to the individual, including the failure to provide an



1 enrollee on a timely basis medically necessary care for which
2 benefits are available under the plan or the failure to provide the
3 covered care in accordance with applicable quality standards.

4 (ii) The organization, or agent or other entity acting on the
5 organization's behalf, materially misrepresented the plan's
6 provisions in marketing the plan to the individual.

7 (D) The Medicare+Choice plan in which the individual is
8 enrolled reduces any of the benefits under the plan or increases the
9 cost-sharing amount or discontinues for other than good cause
10 relating to the quality of care under the plan, a provider who is
11 currently furnishing services to the individual. However, with
12 respect to eligibility under this subparagraph, an individual shall
13 be eligible only for ~~another~~ a Medicare supplement contract issued
14 by the same ~~provider~~ *health care service plan* through which the
15 individual is enrolled at the time the reduction, increase, or
16 discontinuance described above occurs. The change to another
17 plan *contract* may occur only once annually.

18 (E) The individual meets other exceptional conditions as the
19 director may provide.

20 (3) The individual meets both of the following conditions:

21 (A) The individual is enrolled with any of the following:

22 (i) An eligible organization under a contract under Section
23 1876 of the federal Social Security Act (Medicare risk or cost).

24 (ii) A similar organization operating under demonstration
25 project authority, effective for periods before April 1, 1999.

26 (iii) An organization under an agreement under Section
27 1833(a)(1)(A) of the federal Social Security Act (health care
28 prepayment plan).

29 (iv) An organization under a Medicare Select policy.

30 (B) The individual's enrollment ceases under the same
31 circumstances that would permit discontinuance of an individual's
32 election of coverage under the first sentence of Section 1851(e)(4)
33 of the federal Social Security Act as delineated in paragraph (2) of
34 subdivision (b).

35 (4) The individual is enrolled under a Medicare supplement
36 contract and the enrollment ceases because of the following: the
37 insolvency of the issuer or bankruptcy of the nonissuer
38 organization; the involuntary termination of coverage or
39 enrollment under the contract; the issuer of the contract
40 substantially violated a material provision of the contract; or the

1 issuer, or an agent or other entity acting on the issuer's behalf,
2 materially misrepresented the contract's provisions in marketing
3 the contract to the individual.

4 (5) The individual meets both of the following conditions:

5 (A) The individual was enrolled under a Medicare supplement
6 contract and terminates enrollment and subsequently enrolls, for
7 the first time, with any Medicare+Choice organization under a
8 Medicare+Choice plan under Medicare Part C, any eligible
9 organization under a contract under Section 1876 of the federal
10 Social Security Act (Medicare risk or cost), any similar
11 organization operating under demonstration project authority, an
12 organization under an agreement under Section 1833(a)(1)(A) of
13 the federal Social Security Act (health care prepayment plan), or
14 a Medicare Select contract.

15 (B) The subsequent enrollment under subparagraph (A) is
16 terminated by the enrollee during any period within the first 12
17 months of the subsequent enrollment (during which the enrollee
18 is permitted to terminate the subsequent enrollment under Section
19 1851(e) of the federal Social Security Act).

20 (6) The individual, upon first becoming eligible for benefits
21 under Medicare Part A who postpones enrollment in Medicare Part
22 A or Part B while eligible for employer-sponsored coverage,
23 enrolls in a Medicare+Choice plan under Medicare Part C, and
24 disenrolls from the plan by not later than 12 months after the
25 effective date of enrollment.

26 (c) (1) Under paragraphs (1), (2), (3), and (4) of subdivision
27 (b), eligible persons are entitled to a Medicare supplement contract
28 that has a benefit package classified as plan A, B, C, F, and at least
29 one letter-designated plan (H, I, or J, at the discretion of the issuer)
30 that includes coverage for prescription medications, if currently
31 available from an issuer.

32 (2) Under paragraph (5) of subdivision (b), eligible persons are
33 entitled to the same Medicare supplement contract in which they
34 were most recently previously enrolled, if available from the same
35 issuer, or, if not so available, a contract described in paragraph (1)
36 of subdivision (c).

37 (3) Under paragraph (6) of subdivision (b), eligible persons are
38 entitled to any Medicare supplement contract offered by any
39 issuer.



(d) (1) At the time of an event described in subdivision (b) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the contract, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement contracts under subdivision (a). That notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in subdivision (b) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the contract, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement contracts under subdivision (a). That notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

(e) Issuers shall refund any unearned monthly premium paid in advance and terminate coverage upon the request of any insured person.

SEC. 3. Section 1358.24 is added to the Health and Safety Code, to read:

1358.24. A Medicare+Choice organization shall submit to the department all of the information included in any request made by the organization to the United States Department of Health and Human Services Centers for Medicare and Medicaid Services for a modification of a service area of a Medicare+Choice plan it offers. The department shall provide the federal Department of Health and Human Services Centers for Medicare and Medicaid Services an advisory opinion addressing the accuracy of this information and the impact the requested modification would have on the plan's enrollees. The department shall include in its opinion any recommendations to modify the request submitted by the Medicare+Choice organization.

SEC. 4. Section 10192.11 of the Insurance Code is amended to read:

1 10192.11. (a) An issuer shall not deny or condition the
2 issuance or effectiveness of any Medicare supplement policy or
3 certificate available for sale in this state, nor discriminate in the
4 pricing of a policy or certificate because of the health status, claims
5 experience, receipt of health care, or medical condition of an
6 applicant in the case of an application for a policy or certificate that
7 is submitted prior to or during the six-month period beginning with
8 the first day of the first month in which an individual is both 65
9 years of age or older and is enrolled for benefits under Medicare
10 Part B. Each Medicare supplement policy and certificate currently
11 available from an issuer shall be made available to all applicants
12 who qualify under this subdivision and are 65 years of age or older.
13 Medicare supplement contracts A, B, C, F, and at least one
14 letter-designated plan (H, I, or J, at the discretion of the issuer) that
15 includes coverage for prescription medications, if currently
16 available from an issuer, shall be made available to any applicant
17 who qualifies under this subdivision who is 64 years of age or
18 younger and who does not have End-Stage Renal Disease. This
19 section ~~does~~ and Section 10192.12 do not prohibit an issuer in
20 determining premium rates from treating applicants who are under
21 65 years of age and are eligible for Medicare Part B as a separate
22 risk classification. This section shall not be construed as
23 preventing the exclusion of benefits for preexisting conditions as
24 defined in paragraph (1) of subdivision (a) of Section 10192.8.

25 (b) (1) If an applicant qualifies under subdivision (a) and
26 submits an application during the time period referenced in
27 subdivision (a) and, as of the date of application, has had a
28 continuous period of creditable coverage of at least six months, the
29 issuer shall not exclude benefits based on a preexisting condition.

30 (2) If the applicant qualifies under subdivision (a) and submits
31 an application during the time period referenced in subdivision (a)
32 and, as of the date of application, has had a continuous period of
33 creditable coverage that is less than six months, the issuer shall
34 reduce the period of any preexisting condition exclusion by the
35 aggregate of the period of creditable coverage applicable to the
36 applicant as of the enrollment date. The manner of the reduction
37 under this subdivision shall be as specified by the commissioner.

38 (c) Except as provided in subdivision (b) and Section
39 10192.23, subdivision (a) shall not be construed as preventing the
40 exclusion of benefits under a policy, during the first six months,

1 based on a preexisting condition for which the policyholder or
2 certificate holder received treatment or was otherwise diagnosed
3 during the six months before the coverage became effective.

4 (d) An individual enrolled in Medicare by reason of disability
5 will be entitled to open enrollment described in this section for six
6 months after he or she enrolled in Medicare Part B, or if notified
7 retroactively of his or her eligibility for Medicare, for six months
8 following notice of eligibility. Every issuer shall make available
9 to every applicant qualified for open enrollment all policies and
10 certificates offered by that issuer at the time of application. Issuers
11 shall not discourage sales during the open enrollment period by
12 any means, including the altering of the commission structure.

13 There shall be a one-time open enrollment period of ~~180~~ 90 days
14 commencing on January 1, 2004, for all individuals eligible for
15 Medicare by reason of disability who do not have End-Stage Renal
16 Disease *and who did not use the prior one-time open enrollment*
17 *that commenced on January 1, 2001*. Notice of this one-time open
18 enrollment right shall be publicized on the Web sites of the
19 Department of Managed Health Care, the Department of
20 Insurance, and the Department of Aging, through *those*
21 *departments'* written materials directed to Medicare beneficiaries,
22 and by HICAP, beginning January 1, 2003.

23 (e) An individual enrolled in Medicare Part B is entitled to open
24 enrollment described in this section for six months following:

25 (1) Receipt of a notice of termination or loss of eligibility *due*
26 *to the divorce or death of a spouse* or, if no notice is received, the
27 effective date of termination or loss of eligibility *due to the divorce*
28 *or death of a spouse*, from any employer-sponsored health plan
29 including an employer-sponsored retiree health plan. For purposes
30 of this section, "employer-sponsored retiree health plan" includes
31 any coverage for medical expenses that is directly or indirectly
32 sponsored or established by an employer for employees or retirees,
33 their spouses, dependents, or other included insureds.

34 (2) Termination of health care services for a military retiree or
35 the retiree's Medicare eligible spouse or dependent as a result of
36 a military base closure or loss of access to health care services
37 *because the base no longer offers services or because the*
38 *individual relocates*.

39 (f) An individual enrolled in Medicare Part B is entitled to open
40 enrollment described in this section if the individual was covered

1 under a policy, certificate, or contract providing Medicare
2 supplement coverage but that coverage terminated because the
3 individual established residence at a location not served by the
4 plan.

5 (g) (1) An individual whose coverage was terminated by a
6 Medicare managed care plan shall be entitled to an additional
7 60-day open enrollment period to be added on to and run
8 consecutively after any open enrollment period authorized by
9 federal law or regulation, for any Medicare supplement coverage
10 provided by Medicare supplement insurers and available on a
11 guaranteed basis under state and federal law or regulation for
12 persons terminated by their Medicare managed care plan. An
13 individual shall be entitled to an annual open enrollment period
14 lasting 30 days or more, commencing with the individual's
15 birthday, during which time that person may purchase any
16 Medicare supplement policy that offers benefits equal to or lesser
17 than those provided by the previous coverage. During this open
18 enrollment period, no issuer that falls under this provision shall
19 deny or condition the issuance or effectiveness of Medicare
20 supplement coverage, nor discriminate in the pricing of coverage,
21 because of health status, claims experience, receipt of health care,
22 or medical condition of the individual if, at the time of the open
23 enrollment period, the individual is covered under another
24 Medicare supplement policy or contract. An issuer shall notify a
25 policyholder of his or her rights under this subdivision at least 30
26 and no more than 60 days before the beginning of the open
27 enrollment period.

28 SEC. 5. Section 10192.12 of the Insurance Code is amended
29 to read:

30 10192.12. (a) (1) With respect to the guaranteed issue of a
31 Medicare supplement policy, eligible persons are those individuals
32 described in subdivision (b) who apply to enroll under the policy
33 not later than 63 days after the date of the termination of
34 enrollment described in subdivision (b), and who submit evidence
35 of the date of termination or disenrollment with the application for
36 a Medicare supplement policy.

37 (2) With respect to eligible persons, an issuer shall not deny or
38 condition the issuance or effectiveness of a Medicare supplement
39 policy described in subdivision (c) that is offered and is available
40 for issuance to new enrollees by the issuer, shall not discriminate

1 in the pricing of that Medicare supplement policy because of
2 health status, claims experience, receipt of health care, or medical
3 condition, and shall not impose an exclusion of benefits based on
4 a preexisting condition under that Medicare supplement policy.

5 (3) Issuers shall issue coverage with an effective date not later
6 than the date of termination of previous benefits or the date
7 requested on the application ~~but~~, *but* in no event earlier than the
8 date of application for coverage. *Issuers shall issue coverage so*
9 *that there is no duplication or overlap of coverage.*

10 (b) An eligible person is an individual described in any of the
11 following paragraphs:

12 (1) The individual is enrolled under an employee welfare
13 benefit plan that provides health benefits that supplement the
14 benefits under Medicare, and the plan terminates, the individual
15 loses his or her eligibility to continue benefits *due to the divorce*
16 *or death of a spouse*, or the plan ceases to provide some, all, or
17 substantially all of those supplemental health benefits to the
18 individual ~~or~~ *and* the employer no longer provides the individual
19 with insurance that covers all of the payment for the Part B
20 20-percent coinsurance.

21 (2) The individual is enrolled with a Medicare+Choice
22 organization under a Medicare+Choice plan Medicare Part C, and
23 any of the following apply:

24 (A) The organization's or plan's certification, under this part,
25 has been terminated or the organization has terminated or
26 otherwise discontinued providing the plan in the area in which the
27 individual resides.

28 (B) The individual is no longer eligible to elect the plan because
29 of a change in the individual's place of residence or other change
30 in circumstances specified by the secretary, but not including
31 termination of the individual's enrollment on the basis described
32 in Section 1851(g)(3)(B) of the federal Social Security Act, where
33 the individual has not paid premiums on a timely basis or has
34 engaged in disruptive behavior as specified in standards under
35 Section 1856 of that act, or the plan is terminated for all individuals
36 within a residence area.

37 (C) The individual demonstrates, in accordance with
38 guidelines established by the commissioner, either of the
39 following:

1 (i) The organization offering the plan substantially violated a
2 material provision of the organization's contract under this article
3 in relation to the individual, including the failure to provide an
4 enrollee on a timely basis medically necessary care for which
5 benefits are available under the plan or the failure to provide the
6 covered care in accordance with applicable quality standards.

7 (ii) The organization, or agent or other entity acting on the
8 organization's behalf, materially misrepresented the plan's
9 provisions in marketing the plan to the individual.

10 (D) The Medicare+Choice plan in which the individual is
11 enrolled reduces any of its benefits or increases the amount of
12 cost-sharing or discontinues for other than good cause relating to
13 the quality of care under the plan, a provider who is currently
14 furnishing services to the individual. However, with respect to
15 eligibility under this subparagraph, an individual shall be eligible
16 only for ~~another~~ a Medicare supplement ~~contract~~ policy issued by
17 the same ~~provider~~ insurer through which the individual is enrolled
18 at the time the reduction, increase, or discontinuance described
19 above occurs. The change to another ~~plan~~ policy may occur only
20 once annually.

21 (E) The individual meets other exceptional conditions as the
22 commissioner may provide.

23 (3) The individual meets both of the following conditions:

24 (A) The individual is enrolled with any of the following:

25 (i) An eligible organization under a contract under Section
26 1876 of the federal Social Security Act (Medicare risk or cost).

27 (ii) A similar organization operating under demonstration
28 project authority, effective for periods before April 1, 1999.

29 (iii) An organization under an agreement under Section
30 1833(a)(1)(A) of the federal Social Security Act (health care
31 prepayment plan).

32 (iv) An organization under a Medicare Select policy.

33 (B) The individual's enrollment ceases under the same
34 circumstances that would permit discontinuance of an individual's
35 election of coverage under the first sentence of Section 1851(e)(4)
36 of the federal Social Security Act as delineated in paragraph (2) of
37 subdivision (b).

38 (4) The individual is enrolled under a Medicare supplement
39 policy and the enrollment ceases because of the following: the
40 insolvency of the issuer or bankruptcy of the nonissuer

1 organization; the involuntary termination of coverage or
2 enrollment under the policy; the issuer of the policy substantially
3 violated a material provision of the policy; or the issuer, or an agent
4 or other entity acting on the issuer's behalf, materially
5 misrepresented the policy's provisions in marketing the policy to
6 the individual.

7 (5) The individual meets both of the following conditions:

8 (A) The individual was enrolled under a Medicare supplement
9 policy and terminates enrollment and subsequently enrolls, for the
10 first time, with any Medicare+Choice organization under a
11 Medicare+Choice plan under Medicare Part C, any eligible
12 organization under a contract under Section 1876 of the federal
13 Social Security Act (Medicare risk or cost), any similar
14 organization operating under demonstration project authority, an
15 organization under an agreement under Section 1833(a)(1)(A) of
16 the federal Social Security Act (health care prepayment plan), or
17 a Medicare Select policy.

18 (B) The subsequent enrollment under subparagraph (A) is
19 terminated by the enrollee during any period within the first 12
20 months of the subsequent enrollment (during which the enrollee
21 is permitted to terminate the subsequent enrollment under Section
22 1851(e) of the federal Social Security Act).

23 (6) The individual, upon first becoming eligible for benefits
24 under Medicare Part A who postpones enrollment in Medicare Part
25 A or Part B while eligible for employer-sponsored coverage,
26 enrolls in a Medicare+Choice plan under Medicare Part C, and
27 disenrolls from the plan by not later than 12 months after the
28 effective date of enrollment.

29 (c) (1) Under paragraphs (1), (2), (3), and (4) of subdivision
30 (b), eligible persons are entitled to a Medicare supplement policy
31 that has a benefit package classified as plan A, B, C, F, and at least
32 one letter-designated plan (H, I, or J, at the discretion of the issuer)
33 that includes coverage for prescription medications, if currently
34 available from an issuer.

35 (2) Under paragraph (5) of subdivision (b), eligible persons are
36 entitled to the same Medicare supplement policy in which they
37 were most recently previously enrolled, if available from the same
38 issuer, or, if not so available, a policy described in paragraph (1)
39 of subdivision (c).

1 (3) Under paragraph (6) of subdivision (b), eligible persons are
2 entitled to any Medicare supplement policy offered by any issuer.

3 (d) (1) At the time of an event described in subdivision (b)
4 because of which an individual loses coverage or benefits due to
5 the termination of a contract or agreement, policy, or plan, the
6 organization that terminates the contract or agreement, the issuer
7 terminating the policy, or the administrator of the plan being
8 terminated, respectively, shall notify the individual of his or her
9 rights under this section, and of the obligations of issuers of
10 Medicare supplement policies under subdivision (a). That notice
11 shall be communicated contemporaneously with the notification
12 of termination.

13 (2) At the time of an event described in subdivision (b) because
14 of which an individual ceases enrollment under a contract or
15 agreement, policy, or plan, the organization that offers the contract
16 or agreement, regardless of the basis for the cessation of
17 enrollment, the issuer offering the policy, or the administrator of
18 the plan, respectively, shall notify the individual of his or her rights
19 under this section, and of the obligations of issuers of Medicare
20 supplement policies under subdivision (a). That notice shall be
21 communicated within ten working days of the issuer receiving
22 notification of disenrollment.

23 (e) Issuers shall refund any unearned monthly premium paid in
24 advance and terminate coverage upon the request of any insured
25 person.

26 SEC. 6. No reimbursement is required by this act pursuant to
27 Section 6 of Article XIII B of the California Constitution because
28 the only costs that may be incurred by a local agency or school
29 district will be incurred because this act creates a new crime or
30 infraction, eliminates a crime or infraction, or changes the penalty
31 for a crime or infraction, within the meaning of Section 17556 of
32 the Government Code, or changes the definition of a crime within
33 the meaning of Section 6 of Article XIII B of the California
34 Constitution.

